Medicare coverage of kidney dialysis and kidney transplant services

A supplement to Your Medicare Handbook

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Medicare and treatment for permanent kidney failure

This supplement to *Your Medicare Handbook* explains the special rules for Medicare coverage and payment of kidney dialysis and transplant services.

Medicare also helps pay for a wide range of other health services and supplies. *Your Medicare Handbook* describes the other health services and supplies that are covered by Medicare and how payments are made. If you don't have a copy of the handbook, you can get one at any Social Security office.

The two parts of Medicare

Medicare has two parts—hospital insurance and medical insurance. This section briefly describes each part. For more detailed information, see *Your Medicare Handbook.*

Hospital insurance

Hospital insurance covers medically necessary inpatient hospital care. Under certain conditions, it also covers medically necessary inpatient care in a skilled nursing facility after a hospital stay and home health care. The hospital insurance part of Medicare, for example, helps pay for an inpatient stay in an approved hospital for kidney transplant surgery.

Hospital insurance has a deductible which must be met each time your admission to a hospital starts a new benefit period. In 1982, the deductible is $260.

Medicare payments for services covered by hospital insurance are made directly to the participating hospital, skilled nursing facility, and home health agency.

Medical insurance

Medical insurance covers doctors' services, outpatient hospital services, outpatient physical therapy and speech pathology services, and many other health services and supplies.

Most of the services and supplies needed by people with permanent kidney failure are covered **only** by medical insurance. For example, medical insurance covers outpatient maintenance dialysis, self-dialysis training, and home dialysis.

If you became entitled to Medicare before you developed permanent kidney failure and have not signed up for medical insurance or if your medical insurance has stopped, you can apply for this protection now. The amount of your monthly premium will be the current basic rate—$11 through June 30, 1982. If you already have medical insurance but are paying a higher premium, the amount can be reduced to the current basic rate. Get in touch with any Social Security office for more information.

There is a $75 deductible which must be met each year before payments can be made for services and supplies covered by medical insurance. The deductible can be made up of charges for any covered services and supplies. There is not a separate deductible for each covered service. After the $75 annual deductible is met, medical insurance generally pays 80 percent of the recognized charges for covered services you receive during the rest of the year.

When Medicare protection begins

When you become entitled to Medicare because of permanent kidney failure, your Medicare protection starts with the 3rd month after the month your course of maintenance dialysis treatments begin. For example, if you began receiving maintenance dialysis treatments in July, your Medicare coverage would start on October 1st.

There are two ways your Medicare protection can begin earlier.

- Medicare coverage can begin in the *1st month* of dialysis **if** you participate in a self-dialysis training program in a Medicare-approved training facility before the 3rd month after dialysis begins, **and** you are expected to complete the training and self-dialyze thereafter.
- Medicare coverage can begin the month you are admitted to an approved hospital for a kidney transplant or procedures preliminary to a transplant **if** the transplant takes place in that month or within the 2 following months. But, if the transplant is delayed more than 2 months after you are admitted to the hospital, Medicare coverage will begin the 2nd month before the month the actual transplant takes place or, if earlier, the 1st day of the 3rd month after maintenance dialysis began.

When Medicare protection ends

For people entitled to Medicare **only** because of permanent kidney failure, Medicare protection ends 12 months after the month they no longer require maintenance dialysis treatments **or** 36 months after the month of a kidney transplant. But, if the transplant fails during or after that 36-month period and the person again needs maintenance dialysis or another transplant, Medicare coverage will continue or be reinstated immediately without any waiting period.

Your Medicare medical insurance can stop at any time if you fail to pay premiums or if you decide to cancel it.

Who can provide maintenance dialysis and transplant surgery

To receive Medicare payments, medical facilities must be specifically approved to provide maintenance dialysis or kidney transplant surgery—even if they already participate in Medicare to provide other health care services covered by the program.

They must meet special health, safety, professional, staffing, and minimum utilization standards directly related to dialysis and kidney transplant services. And, they must meet Federal, State, and local requirements for medical facility planning.

Your doctor or the facility can tell you whether a facility is approved by Medicare for payment of dialysis and transplant services.

Coverage of maintenance dialysis

This section explains coverage and payment for outpatient maintenance dialysis and the conditions under which inpatient dialysis is covered.

Outpatient dialysis

Medicare medical insurance helps pay for outpatient maintenance dialysis treatments in any approved dialysis facility. This includes the costs of laboratory tests, equipment, supplies, and other services associated with your treatment. Medical insurance payments for outpatient maintenance dialysis are always made to the facility.

Charges for maintenance dialysis will vary from one approved facility to another. The facilities' charges are based on their costs of providing dialysis treatments. The cost of treatment will depend on various factors such as costs of professional services and equipment in the area, the size of the facility, and other justifiable operating costs that can differ between one approved facility and another. A typical charge might be $130 per treatment. In that case, if the $75 annual deductible has already been met, medical insurance would pay 80 percent of $130 (or $104). Medicare **cannot** pay the remaining 20 percent of the charge (or $26).

Occasionally, maintenance peritoneal dialysis treatments will extend overnight. These extended peritoneal treatments are covered as outpatient services by medical insurance. Consequently, any overnight stays will not reduce the number of inpatient days covered by your Medicare hospital insurance unless you require inpatient care for additional specialized services.

Many of the laboratory tests you receive may be included as part of the facility's maintenance dialysis services. But, if you need additional tests, they can be covered as independent laboratory services, outpatient hospital services, or as part of your doctor's services. For more information, see the chapters on doctors' services, outpatient hospital services, and other services and supplies in *Your Medicare Handbook*.

Inpatient dialysis

Generally, maintenance dialysis treatments are covered on an outpatient basis. But if you are admitted to a hospital because your medical condition requires the availability of other specialized hospital services on an inpatient basis, your maintenance dialysis treatments would be covered by hospital insurance as part of the costs of your covered inpatient hospital stay.

Please read pages 12 through 14 of *Your Medicare Handbook* for a detailed explanation of the coverage of inpatient hospital care. You should note that when you are admitted into a hospital as an inpatient, you use hospital days from your Medicare benefit period. This term is explained on page 10 of *Your Medicare Handbook*. To be hospitalized for dialysis may be costly in the long run because you may need your hospital days for some future illness.

Doctors' services and maintenance dialysis

Doctors' services are covered by Medicare medical insurance. While you are on maintenance dialysis, medical insurance can pay for your doctor's services in the following ways.

Your doctor can choose to receive a monthly payment for most of the services you will need during the month. Your doctor can use the monthly payment method whether your maintenance dialysis takes place in an outpatient dialysis facility or at home. When the monthly payment method is used, medical insurance pays 80 percent of the monthly fee minus any part of the $75 annual deductible you have not met.

Services from your doctor which are not related to or not provided at the time of treatment of your kidney condition are not included in the monthly payment. For example, during a visit to your doctor for your kidney condition, you might receive services for bronchitis. All of the services you receive during this visit would be included in the monthly payment. But, any additional visits for follow-up care of the bronchitis would **not** be included in the monthly payment. Additional services of this kind are paid for by medical insurance as explained in *Your Medicare Handbook*.

If your doctor does not choose to use the monthly payment method and you are receiving dialysis treatments in an outpatient facility, his or her services to oversee your dialysis will be included in the facility's bill for each dialysis treatment. These services include your doctor's review of your lab tests and being available to treat you, if necessary, while you are receiving dialysis treatments. When your doctor is paid in this way, any additional services—such as those needed to treat a complication that arises during dialysis—and services you need when you are not being dialyzed, would be paid for by medical insurance as described in *Your Medicare Handbook.*

If you self-dialyze—either in an outpatient facility or at home—and your doctor does not choose the monthly payment method, **all** of his or her services would be paid by medical insurance as described on pages 24 and 25 of *Your Medicare Handbook.*

Self-dialysis training

Self-dialysis training is covered by Medicare medical insurance on an outpatient basis.

Coverage of self-dialysis training includes your instruction and instruction for the person who will assist you with maintenance self-dialysis at home. Medical insurance also covers the maintenance dialysis treatment and laboratory tests and other services and supplies associated with the treatment.

Except under certain conditions described on page 13 of this booklet, Medicare **cannot** cover the cost of paid dialysis aides to assist self-dialysis patients at home. Medicare also **cannot** cover the costs of transportation to and from the outpatient dialysis center, wages that you and your assistant lose while being trained, or the cost of lodging during training.

Charges for self-dialysis training sessions may be higher than for dialysis treatments. While charges will vary from one dialysis facility to another, depending upon the type of facility and its geographic location, a typical charge might be $170 per session. If the annual deductible has already been met, medical insurance would pay 80 percent of this charge (or $136). Medicare **cannot** pay the remaining 20 percent of the charge (or $34).

For the services of the doctor who is conducting your self-dialysis training, the maximum total charge medical insurance will recognize is $500. If this maximum charge is made, medical insurance would pay 80 percent of $500 (or $400) if the deductible has already been met. Medicare **cannot** pay the remaining 20 percent (or $100).

Retraining for self-dialysis—for example, in the use of new equipment—is also covered by Medicare medical insurance on an outpatient basis.

Home dialysis

Medicare medical insurance covers home dialysis equipment, all necessary supplies, and a wide range of home support services. Home dialysis includes home hemodialysis, home intermittent peritoneal dialysis (IPD), and home continuous ambulatory peritoneal dialysis (CAPD).

Home dialysis equipment

Medical insurance covers rental or purchase of kidney dialysis equipment for use in your home. Delivery and installation service charges are included as part of the charge recognized by medical insurance for home dialysis equipment.

Whether you rent or buy dialysis equipment, medical insurance usually makes monthly payments. If you buy dialysis equipment, the monthly medical insurance payment includes any reasonable interest or carrying charges that may be part of an installment purchase agreement with the supplier of the equipment.

After the $75 annual deductible, medical insurance pays 80 percent of the recognized monthly rental charge or the recognized monthly installment purchase price for your home dialysis equipment.

Medical insurance payments for your home dialysis equipment can continue as long as you need to be dialyzed at home. If your need for home dialysis stops, medical insurance payments also stop. For example, if you no longer need to be dialyzed because you have successful kidney transplant surgery, then medical insurance payments for your home dialysis equipment would usually stop.

If you stop using your home dialysis equipment temporarily—for example, because you are traveling or are hospitalized—medical insurance will continue its payments for the equipment for up to 3 months after the month in which you last used the equipment. If at a later date you use the equipment again, medical insurance payments would also start again.

Of course, if you purchase your dialysis equipment, medical insurance payments always stop when the purchase price recognized as a basis for payments is reached.

A special rule applies if you obtain your home dialysis equipment from an approved hospital, facility, or nonprofit third party organization which reserves the equipment for the exclusive use of Medicare patients on home dialysis. If you get your equipment under this arrangement, Medicare will pay the hospital or facility for the full reasonable cost of the equipment, including installation and maintenance for as long as you need it. You do not pay any deductible or coinsurance.

Home dialysis supplies

Medical insurance covers all supplies necessary to perform home dialysis. This includes disposable items such as alcohol wipes, sterile drapes and rubber gloves, forceps, scissors, and topical anesthetics. After the $75 annual deductible, medical insurance pays 80 percent of the recognized charges for all covered services. Whenever possible, you should accumulate bills until they reach $10 or more before sending in your claim for payment.

Drugs **cannot** be covered except for heparin, the antidote for heparin when medically indicated, and topical anesthetics. Also, blood or packed red blood cells **cannot** be covered for home dialysis unless your doctor administers it or personally directs its administration or the blood is needed to prime your dialysis equipment. (See "How Medicare pays for blood" on page 16.)

Home dialysis support services

Medical insurance covers periodic support services, furnished by an approved hospital or facility, which may be necessary to help you remain on home dialysis. After your doctor approves the plan of treatment, such support services may include visits by trained hospital or facility personnel to periodically monitor your home dialysis, to assist in emergencies when necessary, and to **occasionally** serve as a dialysis aide (for example, when your regular partner is temporarily not available because of illness). Medical insurance also covers the services of qualified facility or hospital personnel to help with the installation and maintenance of your dialysis equipment and to test and appropriately treat your water supply system.

Medical insurance can cover the services of a trained dialysis aide to assist with self-dialysis at home if **all** three of the following conditions are met: 1) an approved hospital or facility which is supervising your treatments provides **all** of your home dialysis equipment, supplies, and support services; 2) the services of a trained aide are necessary to enable you to be on self-dialysis at home when a family or household member is not available to help you; 3) the hospital or facility has in effect a special payment agreement with Medicare.*

Under these conditions, after the $75 deductible, medical insurance pays the hospital or facility 80 percent of the recognized cost of providing all covered services.

Kidney transplant surgery

Both parts of Medicare help pay for kidney transplant surgery.

What hospital insurance pays for

Medicare hospital insurance covers your inpatient hospital services in an approved hospital when you are admitted for kidney transplant surgery. Hospital insurance also covers hospital services in preparation for your kidney transplant. This includes the Kidney Registry fee and services such as laboratory and other tests that are required to evaluate your medical condition and the medical conditions of potential kidney donors. These preparatory services are covered whether they are done by the ap-

*Note: Facilities are not *required* to have this special agreement with Medicare. A facility with such an agreement is reimbursed the same amount for each of its home patients, whether or not a home aide is furnished to each patient. The facility must furnish a home aide if one is medically necessary and no other person is available to assist you.

proved hospital where your transplant surgery will take place or by another hospital that participates in Medicare. If there is no kidney donor, the costs of obtaining a suitable kidney for your transplant surgery are also covered.

When your admission to a hospital for transplant surgery starts a benefit period, hospital insurance pays for all covered inpatient hospital services for the 1st through 60th day, **except the $260 hospital insurance deductible.** For the 61st through 90th day, hospital insurance pays for all covered services, **except for $65 a day.**

In addition to 90 inpatient hospital days in each benefit period, you have a lifetime total of 60 inpatient hospital reserve days. Reserve days, however, are **not** renewable. Hospital insurance pays for all covered services **except for $130 a day** for each reserve day you use. (For more information about inpatient hospital care, see "When you are a hospital inpatient" beginning on page 12 in *Your Medicare Handbook.)*

Hospital insurance pays the full cost of care for a person who donates a kidney for your transplant surgery. This includes all reasonable preparatory, operation, and post-operative recovery expenses connected with the donation. There is no deductible or daily amount for your donor's hospital stay, and the number of days your donor uses does not reduce the number of inpatient days that you may use in a benefit period. The inpatient hospital stay does not qualify your donor for any Medicare benefits not associated with the kidney donation. But, Medicare hospital insurance will pay for any additional inpatient hospital care your donor might need if complications result directly from the kidney donation.

Medicare hospital insurance payments are made directly to the hospital.

What medical insurance pays for

Medicare medical insurance covers your surgeon's services for performing the kidney transplant operation. This includes pre-operative care, the surgical procedure, and follow-up care. Medical insurance also covers doctors' services provided to your kidney donor during his or her inpatient hospital stay while you are receiving a kidney transplant.

After the $75 annual medical insurance deductible is met, medical insurance pays 80 percent of the recognized charge for your surgeon's services and the doctors' services provided to your kidney donor.

Some approved hospitals will include your surgeon's fee in their costs for your transplant surgery. In this case, if the $75 annual deductible has already been met, medical insurance pays the hospital for your surgeon's services except for 20 percent of the surgeon's fee. Otherwise, medical insurance payments for your surgeon's services are paid for as explained in *Your Medicare Handbook* (see "How medical insurance payments are made" beginning on page 24 of the handbook).

How Medicare pays for blood

Both parts of Medicare can help pay for blood (whole blood or units of packed red blood cells), blood components, and the cost of blood processing and administration.

If you receive blood as an inpatient of a hospital or skilled nursing facility, hospital insurance can pay all of these blood costs, **except for any nonreplacement fees charged for the first 3 pints of whole blood or units of packed red cells in each benefit period.** The nonreplacement fee is the charge that some hospitals and skilled nursing facilities make for blood which is not replaced.

You are responsible for the nonreplacement fees for the first 3 pints or units of blood furnished by a hospital or skilled nursing facility. If you are charged nonreplacement fees, you have the option of either paying the fees or having the blood replaced. If you choose to have the blood replaced, you can arrange for another person or a blood assurance plan to replace it for you. A hospital or skilled nursing facility **cannot** charge you for any of the first 3 pints of blood you have replaced.

Medical insurance can help pay for blood and blood components you receive as an outpatient or as part of other covered services, **except for any nonreplacement fees charged for the first 3 pints or units received in each calendar year.** After you have met the $75 annual deductible, medical insurance pays 80 percent of the recognized charges for blood starting with the fourth pint in a calendar year.

Medicare does not cover blood in connection with self-dialysis at home unless it is provided as part of a doctor's service or is needed solely for the purpose of priming the dialysis equipment.

What Medicare does not cover

The following list shows some of the services and supplies that Medicare does **not** cover in connection with dialysis and transplant services. Pages 44 and 45 in *Your Medicare Handbook* list other services and supplies which are not covered by Medicare.

Ambulance or other transportation costs to a facility for routine outpatient maintenance dialysis

Dialysis aides' services to assist in home dialysis, except under certain conditions (See page 13)

Drugs and medicines you buy yourself with or without a prescription except heparin, the antidote for heparin, and topical anesthetics

Inpatient hospital and skilled nursing facility costs when the stay is solely for maintenance dialysis

Lodging costs when an outpatient dialysis facility is not near your home

Wage losses to you and your dialysis partner during self-dialysis training

Other payment sources

If you have health care protection from private health insurance, the Veterans Administration, the Indian Health Service, a Federal employee's health plan, or another source, it also may help pay for services you need for the treatment of permanent kidney failure.

In most States, there are agencies that help with some of the medical expenses Medicare does not cover. Some States have Kidney Commissions that assist people in meeting the expenses Medicare cannot pay. And most States have a Medicaid program that helps pay medical expenses in cases of serious financial need.

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